STATE OF MAINE
BOARD OF DIRECTORS OF
THE DIRIGO HEALTH AGENCY

IN RE: DETERMINATION OF	**)**	
AGGREGATE MEASURABLE	**)**	**HEARING BRIEF OF THE**
COST SAVINGS FOR THE SECOND	**)**	**MAINE ASSOCIATION OF**
ASSESSMENT YEAR	**)**	**HEALTH PLANS**

NOW COMES the Maine Association of Health Plans ("MEAHP")[1] as an intervenor in this hearing regarding the determination of "aggregate measurable cost savings" (AMCS") for the second assessment year pursuant to the Dirigo Health Act, P.L. 2003 ch. 469, as amended by P.L. 2005, ch. 400 (the "Act"). The Act prescribes that the Board of Directors (the "Board") of the Dirigo Health Agency ("DHA") determine "annually not later than April 1st the aggregate measurable cost savings [("AMCS")], including any reduction or avoidance of bad debt and charity care costs to health care providers in this State as a result of the operation of Dirigo Health and any increased enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004." 24-A M.R.S.A. §6912(1)(A). In order to satisfy this mandate, the Board has given notice of an adjudicatory hearing to be held on March 28 and 29, 2006.[2]

DHA carries the burden of proving to the Board that its proposed determination of AMCS is grounded in the Act and reasonably supported by evidence in the record. However, DHA has failed to offer any proposed determination of AMCS for the second assessment year. Instead, and despite the April 1st jurisdictional deadline set forth in the Act, DHA has proposed only a vague methodology for determining AMCS, absent any data or calculations. Obviously,

[1] MEAHP is an incorporated trade association of health plans; MEAHP's members are Aetna Health, Inc., Anthem Blue Cross/Blue Shield of Maine, CIGNA Health Care of Maine, and Harvard Pilgrim HealthCare.

[2] MEAHP has a significant interest in both restraining the costs of health care in Maine and extending health insurance coverage to more of Maine's population; to that end, MEAHP has supported and continues to support the laudable goals of Dirigo Health. MEAHP also has a significant interest in this hearing insofar as the determination of AMCS sets the stage for the assessment of a "savings offset payment" ("SOP") against MEAHP. Thus, MEAHP intervened in this hearing in order to ensure that the Board's determination of AMCS was reasonably grounded in the terms of the Act and supported by record evidence.

EXHIBIT 1

then, by withholding data and calculations DHA has made it impossible for the Board to comply with its statutory mandate of determining AMCS by April 1.[3]

At most now, the Board is left to consider DHA's proposed methodology. For the reasons stated herein, the Board should reject DHA's proposed methodology because it is unsupported and unreasonable. In short, DHA's proposal is fatally flawed in several ways: (1) it is not based on standards or guidance contained in the Act; (2) it includes several categories of putative savings that are not contemplated in the Act; (3) it includes putative savings that are neither "a result of the operation of Dirigo Health" nor "due to an expansion of MaineCare enrollment" as the Act requires; (4) it includes putative savings that have not been realized by payors as the Act requires; (5) it includes putative savings that are not "measurable" as the Act requires; and (6) it is so imprecise it is inherently unreasonable. Therefore, the Board should reject DHA's proposed methodology. Instead, for the reasons recited in section 1, below, the Board should conclude that it is impossible to craft a reasonable and rational methodology for determining AMCS according to the Act because the Act provides absolutely no standards to guide any such methodology. Alternatively, if the Board approves some methodology for determining AMCS, that methodology should include only savings which have been realized by payors and which are attributable to "the reduction or avoidance of bad debt and charity care costs to health care providers in this State as a result of the operation of Dirigo Health and any increased enrollment due to an expansion of MaineCare eligibility."

[3] Based on the Board's failure to comply with its jurisdictional statutory deadline for determining AMCS by April 1, DHA and the Board may be precluded from assessing an SOP for the second assessment year.

1. <u>The Act provides absolutely no standards to guide DHA's creation of a proposed methodology.</u>

The Act prescribes that the determination of AMCS shall include:

> Any reduction or avoidance of bad debt and charity care costs to health care providers in this State as a result of the operation of Dirigo Health and any increased enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004.

24-A M.R.S.A. §6913(1). But the Act decidedly does not offer any guidance, standards, mechanisms, formulas, or even measuring dates regarding how and for what periods such putative savings should be calculated. Moreover, at the hearing before the Superintendent of Insurance on October 24, 2005 to consider the Board's proposed determination of AMCS for the first assessment year (the "2005 Hearing"), even the Board's consultants, hired for the very purpose of determining AMCS, conceded that the Act provides absolutely no guidance for doing so. Nancy Kane admitted that the Act "doesn't tell you what a savings is" and that "there was no definition to go by." 2005 Hearing Transcript, Oct. 24, morning, Kane at 25. As a result, Kane simply devised her own methodology for calculating putative savings. 2005 Hearing Transcript, Oct. 24, morning, Kane at 39. Similarly, Steven Schramm of Mercer testified that "there is no language [in the Act] that spells out the methodology of how [alleged savings from hospital voluntary cost restraints] is to be captured or calculated as it relates to savings as a result of Dirigo Health." 2005 Hearing Transcript, Oct. 24, morning, Kane at 111. Thus, the Board's consultants admitted simply crafting guidelines and standards to suit their own calculation of AMCS for the first assessment year where none existed in the Act. The Act has not been revised to provide any such guidance since the hearing on the first assessment year, and DHA has not cited any guidance in the Act in support of the creation of its proposed methodology. Given this

basis, then, any purported methodology for calculating AMCS is unreasonably speculative because the Act provides no fundamental guidance for creating such a methodology.[4]

As if to reinforce the point, DHA's proposed methodology includes the following tremendous caveat: "The methodologies for cost savings that are presented here have been developed in the absence of much of the necessary data. As a result, the final methodologies may require some adjustments when the final data is utilized." DHA Proposed Methodology at 9. This notion – that DHA can rearrange the methodology in order to fit the available data – is simply not reasonable and dramatically demonstrates that the Act itself lacks even minimal standards and criteria.

2. <u>DHA's proposed methodology includes several categories of putative savings that are not contemplated in the Act.</u>

Even if it were possible to craft a reasonable methodology for determining AMCS based on the terms of the Act, such a methodology would have to be limited to the categories of putative savings identified in the Act. Again, the Act prescribes that the determination of AMCS shall include

> Any reduction or avoidance of bad debt and charity care costs to health care providers in this State as a result of the operation of Dirigo Health and any increased enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004.

24-A M.R.S.A. §6913(1). No other provision of the Act directs or even suggests that DHA may include any other sources of putative savings in a calculation of AMCS. Thus, the Act delineates only two possible sources for AMCS: (1) "the reduction or avoidance of bad debt and charity

[4] The lack of guiding standards in the Act means that the Act is unconstitutionally vague, an argument that MEAHP has made in its brief to the Superior Court in the case of <u>MEAHP et al. v. Superintendent, Bureau of Insurance, et al.</u>, Docket No. AP-05-90, concerning the AMCS and SOP for the first assessment year. Also in that case, MEAHP has argued that the Act is unconstitutional insofar as the SOP constitutes an improper delegation of taxing authority. Those arguments apply equally in the context of the second assessment year, and so MEAHP reserves the right to pursue them in any litigation that may follow from this hearing.

care costs to health care providers … as a result of the operation of Dirigo Health" ("BD/CC"); and (2) "any increased enrollment due to an expansion of MaineCare eligibility" ("MaineCare expansion"). 24-A M.R.S.A. §6913(1). "Dirigo Health" is defined in the Act as "an independent executive agency to arrange for the provision of comprehensive, affordable health care coverage…." 24-A M.R.S.A. § 6902. Because the Act essentially defines "Dirigo Health" as State-owned insurance carrier, its "operation" necessarily consists of offering subsidized insurance products. The language of the Act bears this out by referring to "any reduction or avoidance of bad debt and charity care costs" as the only measure attributable to "the operation of Dirigo Health." In fact, Part F of the Act, which enumerates a series of Legislative requests and initiatives, contains neither legislative direction that any resulting savings should be included in the Board's determination of AMCS nor legislative direction regarding how or for what time period such savings might to be determined. Accordingly, only savings resulting from Dirigo Health's insurance activities, as well as the expansion of MaineCare, are properly included in any determination of AMCS.

Despite the limitations of the Act, DHA offers an unrestrained methodology for determining AMCS which includes several categories of putative savings not contemplated in the Act. To wit, DHA claims putative savings derived from the following sources: (1) Hospital Savings Initiatives – *i.e.*, voluntary restraints by hospitals on "cost increases measured as expenses per case mix adjusted discharge" ("CMAD"); (2) Uninsured Savings Initiatives – *i.e.*, BD/CC, MaineCare expansion, and the so-called "woodwork effect" whereby people "came out of the woodwork" to enroll in Dirigo Choice and in MaineCare; (3) Certificate of Need ("CON") and Capital Investment Fund ("CIF") Savings Initiatives – *i.e.* reductions in capital costs and operating expenses for health care providers; and (4) Health Care Provider Fee Savings

Initiatives – *i.e.*, reductions in cost-shifting by providers as a result of payments to providers by the State. But DHA's inclusion of myriad categories of putative savings in its proposed methodology for determining AMCS does not trump the parameters set by the explicit terms of the Act. Thus, only the portion of putative savings derived from BD/CC and MaineCare expansion (subsets of putative savings categorized by DHA as Uninsured Initiatives) may be counted toward a determination of AMCS.

3. DHA's proposed methodology includes putative savings that are neither "a result of the operation of Dirigo Health" nor due to increased MaineCare enrollment as the Act prescribes.

Pursuant to the Act, any putative savings included in the calculation of AMCS must be either "a result of the operation of Dirigo Health" or due to increased MaineCare enrollment. 24-A M.R.S.A. §6913(1). In other words, in order to show putative savings, DHA must show causation. Yet DHA's proposed methodology suggests absolutely no evidence of causation; it simply offers the naked assertion that "Dirigo was the primary driver of positive savings." DHA's Proposed Methodology at 14. But saying it is so does not magically make it so. Moreover, DHA's proposed methodology simply attempts to measure putative savings that have occurred since the Act was passed. But coincidence of timing is not sufficient evidence of causation; coincidence merely supports the logical fallacy known as *post hoc ergo propter hoc* – *e.g.*, the rooster crowed before the sun rose, therefore the rooster caused the sun to rise. The existence of putative savings after the Act was passed does not mean that the Act caused the putative savings.

Furthermore, even assuming, *arguendo*, that some putative savings have been achieved since the Act was passed, the extent of putative savings related to "the operation of Dirigo Health" or increased MaineCare enrollment is moderated by a host of other factors that have

contributed to fluctuations in the costs of health care. See Rottkamp Prefiled at 5-8, and exhibit 1 at 13-16; Fishbein Prefiled at 5, 9; Sheils Prefiled at 7-8 Mercier Prefiled at 8. See also Kenney Prefiled at 5-8; Bubar Prefiled at 6-11; Levesque Prefiled at 3-6. Startlingly, however, DHA's proposed methodology does nothing to separate putative savings related to "the operation of Dirigo Health" or increased MaineCare enrollment from any other factors that may have caused savings in health care costs; instead, DHA blindly assumes that all putative savings are related to "the operation of Dirigo Health" or increased MaineCare enrollment. See Id.

In his Prefiled Testimony, John Sheils offers a litany of other possible factors which could affect health care costs in Maine: "changes in patient volume, changes in patient case mix and payor mix, opening or closing a hospital wing, overtime pay for nurses due to nursing shortages, changes in reimbursement levels from public payors, … overarching trends in the health system, … [and] employer health and wellness programs." Sheils Prefiled at 7. Moreover, DHA's proposed methodology fails to control for the national trend of decreasing health care costs, even though Maine certainly is not immune from the various factors affecting national trends which have nothing to do with "the operation of Dirigo Health" or increased MaineCare enrollment. See Fishbein Prefiled at 10; Rottkamp Prefiled at 5-6, exhibit 1 at 14, and exhibit 1(1)

The last item on Sheils' list is exemplary, and dramatically portrays the perversion built into DHA's proposed methodology. Maine health plans or self-insureds increasingly have sponsored successful wellness or disease management programs – *e.g.*, Bath Iron Works' Building Healthy Ways program, Cianbro's Healthy LifeStyles Program, and Unum's Health Resource Center – which have produced savings in health care costs. See Kenney Prefiled at 5-8; Bubar Prefiled at 6-11; Levesque Prefiled at 3-6; Sheils Prefiled at 7-8. The undeniable

bottom line for such programs is that healthier people need less health care. See Id. Under DHA's misguided proposed methodology, however, savings generated by such wellness efforts will be counted as savings caused by the operation of Dirigo Health. See Sheils Prefiled at 8; Rottkamp Prefiled at 5-8, and exhibit 1 at 13-15. Perversely, then, pursuant to DHA's proposed methodology, health plans and self-insureds stand to be charged (via the SOP based on AMCS) for enabling a healthier population. See Sheils Prefiled at 8. And to doubly ensure that no good deed goes unpunished, DHA's proposed methodology would mean that those companies which offer health insurance to their employees will be forced to subsidize the health insurance for employees of companies, even possible competitors in the marketplace, which do not offer health insurance. See Id.

Moreover, DHA's hired expert Steven Schramm has admitted that the methodology DHA proposed for the first assessment year did not even attempt to account for the variety of factors impacting health care costs; according to the written summary of an August 2, 2005 meeting of the so-called "SOP Working Group," Schramm advised the group that Mercer chose an approach that did not separately identify savings associated with the Dirigo Health Act." Sheils Prefiled at exhibit C(2). And in his testimony in the 2005 Hearing, Schramm admitted that it was "probably impossible to" segregate savings generated by Dirigo Health from savings potentially attributable to a host of other factors known to influence the data the consultants used. 2005 Hearing Transcript, Oct. 24, morning, Schramm at 113-14. Similarly, in her testimony in support of DHA at the 2005 Hearing, Nancy Kane admitted as follows: she never checked with any hospital in Maine to determine whether the putative savings she calculated were actually related to the operation of Dirigo Health; she did not test her methodology to determine "whether there were forces external to Dirigo that created the results [she] measured"; she never tested her

methodology to determine whether it would produce savings in any year prior to implementation of the Act; she did not test her methodology to determine whether it would produce Dirigo-related savings outside the state of Maine; and her methodology could produce savings in times and places not covered by the Act. 2005 Hearing Transcript, Oct. 24, morning, Schramm at 28-29, 49. See Sheils Prefiled at 4.

DHA's current proposed methodology for the second assessment year is unchanged insofar as it again fails to separate "the operation of Dirigo Health" or increased MaineCare enrollment from the wide variety of other factors which may have caused putative savings. Therefore, DHA's proposed methodology for determining AMCS attributable to "the operation of Dirigo Health" or increased MaineCare enrollment is unreasonable, unsupported, and fatally flawed.

4. DHA's proposed methodology includes putative savings that have not been realized by payors as required by the Act.

The statement of "Guiding Principles" set forth in DHA's proposed methodology holds that "*when calculated, the savings will be used to sustain Dirigo Choice at no additional costs.*" DHA's Proposed Methodology at 9 (emphasis added). This "Guiding Principle" is consistent with the language of the Act and the legislative intent behind it which require that AMCS must reflect only savings which have accrued directly to payors and, ultimately, to end purchasers in the system – consumers and employers. After all, the primal justification for having carriers pay an SOP was to "offset" *actual savings* for providers generated by Dirigo Health, which the providers would then pass along to carriers in the form of lower charges. Indeed, this is precisely how the Governor's Office of Health Policy and Finance described this critical provision in the Act in June 2003: "Payments will be made by insurers to Dirigo Health only after savings are shown. Insurers' payments will offset savings so payments will never exceed

the savings." Fishbein Pre-filed at exhibit 2. And during debate on the original Act, Representative Glynn testified as follows:

> Essentially the way the offset payments are going to be assessed is that when folks sign up for Dirigo it is anticipated that there is going to be a reduction in bad debt and charity care at doctor's offices and hospitals … Those savings are expected to be reflected in reductions and rates at hospitals and at doctor's offices. It is then expected that because the savings are reduced at doctor's offices and hospitals that that savings in turn is going to be passed onto the insurance carriers, which, in turn, will ultimately be passed on to the businesses and also passed onto the consumer.
>
> This was an area that was substantially negotiated and one that helped earn the support for the Majority Report that we are debating this evening. Why this is important is the tax that is going to be assessed, it is a tax, can only be assessed to a maximum of whatever the savings is actually going to be realized … The language in the bill is intended to set a maximum amount that this tax can ever be assessed at 4 percent. However, which is important, is the tax that will be assessed up to that maximum cap will never be greater than the bad debt and charity care that are actually going to be realized by both the hospitals and doctor's offices, <u>that is then realized by the insurance carriers, which then will offset that tax</u>. (emphasis added)

Legislative Record, House, June 12, 2003 (remarks of Rep. Glynn, S. Portland).

Moreover, §6913(9) of the Act requires that filings with the Superintendent in support of health insurance rates or rating formulas reflect, as part of the claims experience, "known changes in payments by the carrier to health care providers in this State, including any reduction for bad debt and charity care costs to health care providers in this State as a result of the operation of Dirigo Health" as well as any post-June 30, 2004 expansion in MaineCare enrollment "as determined by the [B]oard consistent with subsection 1." 24-A M.R.S.A. §6913(9). "[K]nown changes and offsets in payments" is another term for "realized" savings, meaning that the only savings recognized in a rate filing case (for purposes of offsetting the

amount of premium to be charged) would be "realized" savings related to "any reduction for bad debt and charity care … as a result of the operation of Dirigo Health."

Instead of following DHA's "Guiding Principle," the terms of the Act, and the relevant legislative intent, however, DHA's proposed methodology adopts the misguided notion that all putative reductions in the overall cost of health care which are "recoverable" by payors may be included in the methodology for determining AMCS. But the record evidence does not support the notion that putative savings included in DHA's proposed methodology are "recoverable" by payors.

As a starting point, payors cannot "recover" 100% of putative savings in the health care system in the future given that approximately 50% of the Maine market is insured under MaineCare and Medicare. See Mercier Prefiled at 17. Also, despite the obvious intent of the Legislature, DHA's proposed methodology focuses solely on the providers' costs, stopping well short of the Legislature's target of reducing costs to payors. For example, merely showing that certain hospitals have reduced their cost per case mix adjusted discharge, or have voluntarily reduced their consolidated operating margins, does not establish that any payor's spending on health care has been reduced. See Mercier Prefiled at 8-17.

And as another example, at least two of Maine's payors – Aetna and CIGNA – have not experienced any meaningful reduction in their overall growth of spending for health care as a result of Dirigo Health or an expansion of MaineCare enrollment, or, for that matter, as a result of any of the other categories of putative savings contained in DHA's proposed methodology. See Fishbein Prefiled at 9; Rottkamp Prefiled at 6. If DHA's operations, in conjunction with the Legislature's pleas (in Part F of the Dirigo law) for cost restraint, had in fact produced cost savings, Maine payors would be able to confirm this. Unfortunately, the witnesses testifying in

this proceeding who have direct experience in dealing with providers have seen little or no impact as a result of Dirigo Health or an expansion of MaineCare enrollment. Jennifer Rottkamp of CIGNA noted a slight easing of hospital cost increases during the period under review in this case, but observed that if Maine hospitals have enjoyed cost savings "the hospitals do not appear to have passed more than a small portion of them on to us. In fact, the hospitals continue to advise our provider contracting staff that their savings resulting from reduced bad debt and charity care have been largely offset by expansions in MaineCare." Rottkamp Prefiled at 6. And Dr. Fishbein of Aetna noted that although Aetna has seen some temporary reductions in charges by two Maine hospitals, "Aetna has seen no net reductions in hospital charges either from these particular hospitals, or from Maine hospitals in general." Fishbein Prefiled at 9.

Dr. Fishbein then expanded on the "offset" noted by Ms. Rottkamp. Citing legislative testimony in February, 2006 in opposition to LD 1935 by Stephen Michaud, President of the Maine Hospital Association ("MHA"), and Elizabeth Mitchell, Director of Government and Employer Relations at MaineHealth, Dr. Fishbein related that MaineCare payments to hospitals were cut by nearly $34 million for the state's fiscal year ending June 30, 2005. See Fishbein Prefiled at 6, exhibits 2 and 3. According to MHA and MaineHealth, as well as Dr. Fishbein, the reduction in MaineCare payments effectively wiped out any savings the hospitals might have seen as a result of the expansion of MaineCare enrollment (or, for that matter, the operation of Dirigo Health). See Id. at 7, exhibits 2 and 3. Additionally, the hospitals made up for the nearly $34 million cut in MaineCare payments by shifting costs onto private-sector payors. See Id. at 7-8, exhibits 2 and 3.

As noted above, any putative savings must be realized by payors before they can be counted in AMCS. But DHA's proposed methodology fails to account for the multivalent

disconnections between any putative savings in the health care system and realization of those putative savings by payors. Therefore, DHA's proposed methodology – which counts a great range of putative reductions in the overall cost of health care, whether or not realized (or even realizable) by payors, within the ambit of AMCS – is completely unreasonable and contrary to the record evidence.

5. DHA's proposed methodology includes putative savings that are not "measurable" as the Act requires.

Section 6913(1) of the Act explicitly provides that the "cost savings" must be "measurable." To be "measurable" (*i.e.* capable of being measured), the methodology must be based, to the extent possible, on data that is objective, verifiable, and attributable to a particular cause. But DHA's proposed methodology does not allow for a "measurable" determination of AMCS; instead, it contains putative savings that are purely speculative, conjectural, and unattributable. As is made clear above, the methodology for calculating AMCS is thoroughly flawed, *inter alia*, because it includes putative savings that are unrelated to "the operation of Dirigo Health" or the increased MaineCare enrollment, and that have not been realized by payors. Without attention to these boundaries, an accurate determination of "measurable" AMCS pursuant to DHA's proposed methodology is impossible.

6. DHA's proposed methodology is so imprecise it is inherently unreasonable.

Beyond the overarching structural flaws described above which permeate DHA's proposed methodology and extend across the various categories of putative savings posited by DHA, more precise analysis of the specific alleged categories of putative savings is impossible

because the precise nature of DHA's proposed methodology is so utterly clouded.[5] According to John Sheils, "it is difficult to know exactly what the methodology will be because the descriptions of the various methodologies are somewhat vague and open to interpretation." Sheils Prefiled at 8. As an example of the confounding ambiguity in DHA's proposed methodology, Roland Mercier, noted that "[t]he narrative describing CMAD methodology on page 15 does not define: (1) how expenses will be 'combined'; (2) the exact source of 'appropriate revenues and expenses'; (3) how statistics will be 'projected'; (4) how statistics will be 'compared'; and (5) how or why interest will be applied, among other items." Mercier Prefiled at 7. And as for CON, Sheils "is unable to determine exactly what the proposed methodology is from the description." Sheils Prefiled, at 10. Finally, DHA's proposed methodology acknowledges its own inadequacy by stating that "the final methodologies may require some adjustments when the final data is utilized." DHA's Proposed Methodology, at 9. Even DHA is unsure whether its own proposed methodology is accurate. Under these conditions – a shroud of gauzy generalities and ambiguities – DHA's proposed methodology may not be deemed reasonable.

CONCLUSION

For all of the reasons stated above, the Board should reject DHA's proposed methodology. Instead, the Board should recognize that it is impossible to craft a reasonable and rational methodology for determining AMCS according to the Act because the Act provides absolutely no standards to guide any such methodology. Alternatively, if the Board approves

[5] Because DHA's proposed methodology is so vague and admittedly subject to change, MEAHP reserves the right to challenge at the hearing aspects of DHA's proposed methodology which may not be addressed in this brief.

some methodology for determining AMCS, that methodology should include only savings which have been realized by payors and which are attributable to "the reduction or avoidance of bad debt and charity care costs to health care providers in this State as a result of the operation of Dirigo Health and any increased enrollment due to an expansion of MaineCare eligibility."

Dated: March 24, 2006

/s/George M. Linge

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CERTIFICATE OF SERVICE

I hereby certify that on March 24, 2006, the foregoing documents were served electronically and two copies hand delivered via courier upon:

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